EMORY
REPRODUCTIVE CENTER

Name:
Medical Record Number:
Date of Birth:

NEW PATIENT HISTORY FORM

Date: _____ Physician who referred you _____ Fax: _____
Phone: _____

Would you like a letter sent? If yes, sign here _____

DEMOGRAPHIC INFORMATION

Preferred Name, Pronoun: _____
Legal Name: _____ Age: _____ Date of Birth: _____
Occupation: _____ Best Phone: _____

Is your real age different from your legal age? ____ Yes _____ No

REASON FOR VISIT

_____

_____

INFERTILITY HISTORY

How long have you been trying to get pregnant? _____ years _____ months

Have you attempted pregnancy prior to this relationship? ____Yes ____No

Past Fertility Evaluation

Semen Analysis	☐ No ☐ Yes	Result / date _____
HSG (X-ray of tubes)	☐ No ☐ Yes	Result / date _____
Ovulation Predictor	☐ No ☐ Yes	Result / date _____
TSH	☐ No ☐ Yes	Result / date _____
Day 3 FSH, Estradiol	☐ No ☐ Yes	Result / date _____
AMH	☐ No ☐ Yes	Result / date _____

Have you had any of the following treatments?

Clomiphene (Clomid) or Letrozole (Femara) _____
Gonadotropins _____
Prior Inseminations (IUIs) _____

Prior in vitro fertilization (IVF)

Location	Date	Dose	Peak Estrogen	# Eggs Retrieved	% Fertilization (Embryos available)	# Embryos Transferred, Stage	Outcome	Frozen Embryos?

OBSTETRICAL HISTORY

Date	Time to conceive	Length of pregnancy (weeks)	Gender	Birth weight	Outcome (e.g. miscarriage, ectopic, abortion, live birth)	Pregnancy Complications

GYNECOLOGIC and MENSTRUAL HISTORY

Age of onset of periods _____ Date of last menstrual period (LMP)_____

Length of menses _____days Number of days between menses_____days/months

How many pads/tampons do you use on the heaviest day of your period? _____

Do you have pain during your period? ☐ No ☐ Yes

If yes, does it affect your daily activities? ☐ No ☐ Yes

Do you have pain between periods? ☐ No ☐ Yes

Do you bleed between periods? ☐ No ☐ Yes

Any history of any sexually transmitted infections? _____

Date and result of last Pap Smear _____

Any history of abnormal Pap Smears? _____

Have you had surgery or laser of the cervix? ☐ No ☐ Yes

Date and result of last mammogram _____

Do you have any problems with intercourse? ☐ No ☐ Yes

Do you bleed during or after intercourse? ☐ No ☐ Yes

Do you have pain during or after intercourse? ☐ No ☐ Yes

In-utero exposure to DES (diethylstilbestrol) ☐ No ☐ Yes

Have you used an IUD? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes

PAST MEDICAL HISTORY (Please list any medical problems below)

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY *(*Please list all surgeries including dates, hospitalization duration, and location)

1. _____
2. _____
3. _____
4. _____

MEDICATIONS (including complementary and alternative therapy, herbs, vitamins)

1. Vitamin/Folate ☐ Yes ☐ No
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES TO MEDICATIONS; TYPE OF REACTIONS

_____
_____
_____

SOCIAL HISTORY Please select one

⊙ Married ○ Widowed ○ Separated ○ Divorced ○ Single ○ Single in committed relationship

How much caffeine do you drink per day? _____ cups of coffee / tea / soda

Do you smoke? _____ Use any recreational substances? _____

If yes, how much? _____ for ___ years

How much alcohol do you drink per week? _____

What kind? _____

Patient's ethnicity:

☐ Non- Hispanic White ☐ Non- Hispanic Black ☐ Asian/ Pacific Islander ☐ Hispanic ☐ Jewish

Partner's ethnicity (if applicable):

☐Non- Hispanic White ☐Non- Hispanic Black ☐Asian/ Pacific Islander ☐ Hispanic ☐Jewish

Are you interested in pre-genetic conception screening? ☐Yes ☐No

REVIEW OF SYSTEMS

Please mark any of the following disorders YOU currently have or have a history of:

Central Nervous System
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Difficulty with memory

ENT:
- ☐ Visual disturbances
- ☐ Sinus problems

Cardiovascular:
- ☐ High blood pressure
- ☐ High blood pressure in pregnancy
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ History of Rheumatic Fever
- ☐ Heart valve disease
- ☐ Given prophylactic antibiotics
- ☐ Mitral valve prolapse

Respiratory
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough
- ☐ Tuberculosis

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Hepatitis/Liver disease
- ☐ Diarrhea
- ☐ Constipation

Psychiatric
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Depression
- ☐ Eating disorders

Gynecologic
- ☐ Bladder infections (cystitis)
- ☐ Incontinence
- ☐ Kidney infections
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Herpes
- ☐ Syphilis
- ☐ Warts (HPV)
- ☐ Decreased sex drive
- ☐ Pelvic inflammatory disease (PID)
- ☐ Pelvic pain
- ☐ Endometriosis
- ☐ Breast discharge
- ☐ Hot flashes / Night sweats

Musculo-Skeletal
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematous
- ☐ Bone fractures

Hematological
- ☐ Anemia
- ☐ Blood clotting disorder
- ☐ Bleeding tendency
- ☐ Sickle cell anemia or trait

Endocrine
- ☐ Diabetes
- ☐ Diabetes in pregnancy
- ☐ Thyroid disease
- ☐ Heat or Cold intolerance (circle)
- ☐ Excessive hair growth
- ☐ Other: Rapid weight gain/loss (circle)
- ☐ Excessive thirst or hunger (circle)
- ☐ Acne/Skin Problems

Constitutional
- ☐ Flu-like symptoms or fatigue
- ☐ Increase or decrease in appetite (circle)
- ☐ Weight gain or loss (circle)
- ☐ Fevers or chills
- ☐ Fatigue

FAMILY HISTORY

Fill in the appropriate circles to identify all illnesses or conditions which you know have occurred in your blood relatives or partner.

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	Partner
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer/Rectal Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abnormal Bleeding (Bleeding Disorder)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Endometriosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Psychiatric/Mental illness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anesthesia complications	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Miscarriages	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Down Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stillbirth	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thalassemia/Sickle cell	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cleft Lip or Palate, Spina bifida	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tay Sachs, Guacher, Canavans Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neurofibromatosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐

PARTNER HISTORY

Legal Name: _____ Preferred Name, Pronoun: _____

Birth date: _____ Age_____ Occupation _____ Relationship duration _____

Has partner initiated a pregnancy in a previous relationship? ☐ No ☐ Yes

If yes, please give outcome of pregnancy (live birth/ miscarriage, termination) _____

Any pregnancy with birth defects/Genetic disorder/stillbirth/ miscarriage? _____

Has partner had infertility in a previous relationship? ☐ No ☐ Yes

Any history of the following? (Urological)

Prostatitis	☐ No ☐ Yes
Epididymitis	☐ No ☐ Yes
Orchitis	☐ No ☐ Yes
Previous vasectomy	☐ No ☐ Yes
Testicular tumor	☐ No ☐ Yes
Injury to testes	☐ No ☐ Yes
Undescended testicles	☐ No ☐ Yes
Gonorrhea	☐ No ☐ Yes
Chlamydia	☐ No ☐ Yes
Syphilis	☐ No ☐ Yes
Nonspecific urethritis	☐ No ☐ Yes
Difficulty with erection	☐ No ☐ Yes
Difficulty with ejaculation	☐ No ☐ Yes
Exposure to radiation	☐ No ☐ Yes
Exposure to chemicals	☐ No ☐ Yes
Exposure to toxic substances	☐ No ☐ Yes
Exposure to high temperatures	☐ No ☐ Yes

Gynecological history of female partner

Age of onset of periods _____
Date of last menstrual period (LMP) _____
Length of menses ____ days
Number of days between menses _____ days/months
How many pads/tampons do you use on the heaviest day of your period? _____

Do you have pain during your period?	☐ No ☐ Yes
If yes, does it affect your daily activities?	☐ No ☐ Yes
Do you have pain between periods?	☐ No ☐ Yes
Do you bleed between periods?	☐ No ☐ Yes

Any history of any sexually transmitted infections?
_____

Date and result of last Pap Smear _____
Any history of abnormal Pap Smears? _____

Have you had surgery or laser of the cervix?	☐ No ☐ Yes
Date and result of last mammogram	_____
Do you have any problems with intercourse?	☐ No ☐ Yes
Do you bleed during or after intercourse?	☐ No ☐ Yes
Do you have pain during or after intercourse?	☐ No ☐ Yes
In-utero exposure to DES (diethylstilbestrol)	☐ No ☐ Yes
Have you used an IUD?	☐ No ☐ Yes
Have you had a tubal ligation?	☐ No ☐ Yes

PARTNER MEDICAL HISTORY

Weight_____ Height _____

PAST MEDICAL HISTORY (Please list any medical problems below)

1._____

2._____

3._____

PAST SURGICAL HISTORY (Please list any surgical procedures including dates and location)

1._____

2._____

MEDICATIONS (including supplements, hormones, steroids)

	Medication	Reason	Dates/Duration/Last time taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

ALLERGIES

_____

_____

SOCIAL HISTORY

How much caffeine does you partner drink per day? _____ cups caffeine / tea / soda

How many cigarettes does you partner smoke per day? _____ cigarettes For how long? ____years

How much alcohol does you partner drink per week? _____ What kind? _____

How often do you use marijuana? _____

Any other substances? _____

MD NOTES: